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Introduction to the Protection of Conscience Project

Thank you for the invitation to appear before the panel.

The Protection of Conscience Project supports health care workers who want to provide the best care for their patients without violating their own personal and professional integrity. It is a non-denominational, non-profit initiative supported by an Advisory Board and team.

The Project does not take a position on the morality of contentious procedures. In the present case, for example, it takes no position on whether or not legalization of physician assisted suicide and euthanasia is acceptable. Instead, it critiques policies of coercion and encourages accommodation of objecting health care workers.

The people best placed to deal with a problem are those directly involved. Hence, while it is often necessary to explain why a particular procedure, service or action may be objectionable to some health care workers, the Project does not purport to speak for or to represent physicians or other health care workers on these issues; they must speak for themselves. The Project speaks to principles concerning freedom of conscience and the accommodation of freedom of conscience.

As the opportunity arises, the Project responds to critics and draws attention to attitudes, policies and laws that fail to make sufficient allowance for legitimate freedom of conscience.

You have provided one such an opportunity, for which, once more, I thank you.

With respect to what experience or particular knowledge the Project brings to the panel, it has been in operation for over 15 years. The Project has filed submissions with regulatory authorities and parliamentary committees in Canada, the United States, Ireland, the United Kingdom and Europe. Project resources or materials have been cited in over a dozen books published since 2006, in articles in a number of professional journals - not always favourably - and in an intervention at the United States Supreme Court.

With respect to the subject of the present submission, its three part article on Quebec's draft euthanasia bill was translated into Turkish and published in the *Comparative Current Criminal Law Series* by Özyeğin University in Istanbul. And I am here because the Project jointly intervened at the Supreme Court of Canada in the *Carter* case.

One point I wish to emphasize at the outset is that having to speak defensively can create the impression of a kind of combat situation - physician vs. patient. That is not what is intended. Physicians I have spoken with care deeply for their patients, and what we have to say presumes that kind of relationship. Unfortunately, the subject of the discussion can eclipse that.

Outline of this submission

I will first discuss terminology, the language I will be using, so as not to shock people. I will then explain the concept of freedom of conscience that informs the work of the Project. Next I will discuss the obligation to kill, which is related to failed euthanasia attempts and urgent requests for euthanasia or assisted suicide. I will then discuss eligibility criteria and key terms, which are issues that concern the panel. Much of my time will be spent on referral, and I will be relating referral to the risks to society, another of the panel's concerns, and to safeguards. I will offer examples of model policies.

Terminology

I will be using the words kill, homicide, suicide, and euthanasia, and using them quite casually. As Beauchamp and Childress note, "The term killing does not necessarily entail a wrongful act or a crime."[1] Neither does homicide. Suicide is not a crime, nor is attempting suicide.

- The fundamental premise of the *Carter* decision that determined the trajectory and outcome of the case is that suicide can be a rational and moral act, so that assisted suicide and euthanasia can be rational and moral acts (Tab 13, p. 12-14).
- That "medical aid in dying" as defined in Quebec's euthanasia law means killing or homicide was acknowledged by those who support the law. (Tab 14, p. 56-57)
- The Canadian Medical Association uses the terms "medical aid in dying" or "assisted dying" to mean both euthanasia and assisted suicide.

While this explicit terminology is unwelcome in some quarters, the Project continues to use it for three reasons.

First: from the perspective of those who object to euthanasia and assisted suicide for reasons of conscience, these terms allow them to succinctly and clearly express the basis for their opposition. To disallow the terminology impairs their ability to defend themselves and articulate their reasoning.

Second: it keeps the moral/ethical issues that are of concern to conscientious objectors front and centre. Terms like 'medical aid in dying' tend to obscure these issues and encourage the pretence that laws permitting euthanasia and assisted suicide or support for the procedures are morally neutral. They are not.

Third: the failure to distinguish between euthanasia and assisted suicide obscures the fact that more

physicians are willing to provide assisted suicide than euthanasia. Whether or not one accepts the moral distinction, this has some practical consequences that I will discuss today.

Freedom of conscience

A brief discussion of freedom of conscience as it relates to the work of the Project is in order because, contrary to what one might expect, it is not well understood. For example, the 1948 *Universal Declaration of Human Rights* was, apparently, the first statute that distinguished freedom of conscience from freedom of religion.

The Project's interest in freedom of conscience for health care workers does not exclude recognition that patients are legally entitled to access morally contested procedures. The goal is to accommodate the fundamental freedom of health care workers without obstructing or harming patients. I pause here to note that what constitutes "obstruction" and "harm" is now disputed.

As I have noted, the Project does not take a position on the acceptability of morally contested procedures. The question we pose is, "If you think that X is good thing and ought to be provided, what will you do to ensure that those who disagree with you are not forced to be complicit in X, or disadvantaged for refusing to provide or facilitate it?"

This focus on refusal is deliberate and principled. Freedom of conscience is exercised in two different ways.

- The first is by pursuing some good that one thinks should be done: perfective freedom of conscience, because the pursuit of the good as one understands it is thought to be perfective of the human person.
- The second involves refusing to do what one believes to be wrong: preservative freedom of conscience - preservative of personal integrity.

We argue that preservative freedom of conscience - refusing to do what one believes to be wrong - is the more essential. It is the condition necessary for the exercise of perfective freedom of conscience, and the condition necessary for the existence of any human society. Hence, the Project's advocacy is limited to this more fundamental manifestation of freedom of conscience: refusing to do what one believes to be wrong.

You can find this argument explained and developed in more detail in *Freedom of Conscience in Health Care: Distinctions and Limits*, the paper at Tab 3.

As far as I know, this distinction has not been made in *Charter* jurisprudence dealing with the limitation of freedom of conscience and religion. Instead, one repeatedly encounters the kind of claim made by the Ontario Human Rights Commission: that physicians can be forced to do what they believe to be wrong because freedom of conscience is limited; the freedom to hold beliefs is wider than the freedom to act upon them.

"The freedom to hold beliefs is wider than the freedom to act on them." I call this the Trinity Western mantra, because it was enunciated by the Supreme Court of Canada in *Trinity Western University vs. the B.C. College of Teachers*.[2] It has become one of the favourite sayings of Canadians bent upon suppressing freedom of conscience and religion.

But it could also be called Oliver Cromwell's mantra, because the Lord Protector articulated and used exactly the same principle to suppress the practice of Catholicism in Ireland.[3]

Well, the freedom to hold beliefs IS broader than the freedom to act upon them. This is true, but it is inadequate. A principle suitable for a public policy of religious persecution in a 17th century dictatorship is not sufficiently refined to serve as a principle of public policy in a 21st century liberal democracy.

A further distinction between perfective and preservative freedom of conscience is necessary. The freedom to refuse to do what one believes to be wrong is, by its nature, already a very limited freedom - much more limited than perfective freedom of conscience.

You can see this by considering a resolution adopted by the Canadian Medical Association in 2014.

> The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in CMA's policy on euthanasia and assisted suicide.(Tab 7, p. 29, 32)

This motion - resolution - which was later incorporated into CMA policy - expressed support not only for physicians who refuse to kill patients or assist in suicide for reasons of conscience - the preservative freedom of conscience that is the subject of the Project's concern - but also for those who are willing to do so, in accordance with their convictions - perfective freedom of conscience.

Unnoticed at the time was the fact that the CMA's promise to support physicians who provide euthanasia and assisted suicide was not qualified or circumscribed by any criteria for the procedures beyond criteria that might be specified in law. The Supreme Court provided the criteria in February, but, eight months later, we are still trying to figure out how to implement the *Carter* decision.

This demonstrates that accommodating the exercise of perfective freedom of conscience demands much, much more from society than accommodating refusal to do what one believes to be wrong. This is one of the distinctions ignored by the mantra taken from the Supreme Court of Canada ruling in *Trinity Western vs. the College of Teachers* or the *Declaration of the Lord Lieutenant of Ireland*.

The obligation to kill

I will touch briefly here on the obligation to kill, because this has some serious practical implications. The general issues associated with a professional obligation to kill and its relationship to euthanasia and assisted suicide are discussed in some detail at Tab 7, p. 24 to 26. More particularly, in the case of the Quebec euthanasia law, see Tab 12 in Part 5, beginning at p. 71.

In the spring of 2014, CMA ethicist Dr. Jeff Blackmer and then CMA President Dr. Louis Hugo Francesscutti acknowledged that legalization of euthanasia and physcian assisted suicide would impose an obligation to kill upon Canadian physicians. (Tab 7, p. 24) They did not develop this further, and the point has not received sufficient attention since then, but it has practical implications for the provision of euthanasia and assisted suicide, and it is very important for physicians who object to killing patients or helping them commit suicide.

An obligation to kill is not the same as the authority to use deadly force the law grants to people

acting in self defence, the police or soldiers in combat. Neither the police nor soldiers have an obligation to kill. In common law jurisdictions, an obligation to kill has, historically, been imposed only on public executioners.

A physician who agrees to help lethally inject a patient or help him commit suicide would seem to have accepted an obligation to do something that will result in the patient's death, and to do it according to accepted standards. This obligation seems implicit in the agreement.

Such an obligation is implied in the Quebec euthanasia law, which requires a physician who has administered a lethal substance to a patient to remain with the patient "until death ensues,"[4] and practically demonstrated by the provision of euthanasia kits that include two courses of lethal medication in case the first does not work.[5]

The obligation to kill is particularly relevant with respect to two problems that I will now consider. The first is a failed euthanasia or assisted suicide attempt. The second is an obligation to kill in urgent situations.

Failed attempted suicide/euthanasia attempts

The problem of failed euthanasia or assisted suicide attempts concerns one of the issues the panel must address: the different ways in which physicians may cause the death of patients under the terms of the *Carter* ruling: by assisted suicide or by voluntary euthanasia.

The first point to note is that euthanasia and assisted suicide drugs do not always cause death as expected.[6] However, the recommendations recently approved by the Canadian Medical Association (Tab 9, p. A2-3) and draft policy of the College of Physicians and Surgeons of Saskatchewan (Tab 10, p. 4, 1.4) do not take this into account, while the draft policy of the College of Physicians and Surgeons of Alberta (Tab 11, p.6) is not clear about it.

The second point is that more physicians appear to be willing to participate in assisted suicide than euthanasia. This is usually overlooked because CMA officials prefer to use their term "medically assisted dying," which encompasses both.

CMA statistics indicate that 27% of physicians are willing to provide assisted suicide, but only 20% are willing to provide euthanasia.[7,8,9,10,] The statistics appear to be based on an internal survey of less than 2% of the CMA membership, and it is not certain they can be reliably extrapolated to the entire profession. However, the difference was sufficient to cause some anxiety for CMA officials in the months following the *Carter* ruling.

I repeat here what I said earlier. A physician who agrees to help a patient commit suicide would seem to have accepted an obligation to do something that will result in the patient's death.

In the case of a failed physician-assisted suicide that incapacitates a patient, it is likely that the responsible physician will be expected to fulfil his commitment to help bring about the death of the patient by providing a lethal injection. The expectation would be stronger if the patient had sought assisted suicide to avoid the kind of incapacitation caused by the failed suicide attempt. Here the issue of physicians willing to assist in suicide but unwilling to provide euthanasia becomes acute.

Those willing to assist with suicide but not euthanasia may also be reluctant or unwilling to ask

another colleague to kill an incapacitated patient who has not succumbed to assisted suicide drugs. The draft policy of the College of Physicians and Surgeons of Alberta appears to prohibit this. (Tab 11, p. 7, item 9: Ongoing capacity)

Moreover, the *Carter* ruling limits the provision of euthanasia to competent patients. Thus, to ask physicians to kill a patient who has been rendered incompetent by a colleague's failed attempt would seem to expose them to prosecution for first degree murder or, at least, assisted suicide.

Recommendations to avoid conflict following failed attempts

The first four recommendations offered by the Project are intended to avoid or minimize conflicts of conscience arising in this kind of situation.

> 1) Physicians should not undertake to provide assisted suicide unless they are also willing to provide euthanasia.
>
> 2) In all cases, the responsible physician should, as part of the informed consent discussion preliminary to decision making, advise the patient of the possibility that the drugs might not cause death and discuss the options available.
>
> 3) Immediately prior to administering or providing the lethal medication, the responsible physician should obtain written direction from the patient as to what action should be taken if the prescribed or administered drugs fail to cause death. (NB. In the case of patients incapacitated by failed euthanasia/assisted suicide, it is not known if this would be legally sufficient to invoke the exemption from prosecution provided by *Carter*.)
>
> 4) The responsible physician should personally administer the lethal drug or be personally present when it is ingested, and remain with the patient until death ensues.

The fourth recommendation is consistent with a similar requirement in Quebec's *Act Respecting End of Life Care*. It minimizes the likelihood of conflict among other physicians or health care workers that might arise if responsible physicians were permitted to delegate the lethal act to others. In this respect, the recommendations of the CMA, the College of Physicians and Surgeons of Saskatchewan and the College of Physicians and Surgeons of Alberta concerning euthanasia and assisted suicide are unsatisfactory:

- CMA (Tab 9, p. A2-4) Stage 3: After undertaking assisted dying. 11.
- CPSS (Tab 10, last sentence in the draft assisted dying policy)
- CPSA (Tab 11) Silent.

Urgent situations

From failed attempts we move now to the possibility that the obligation to kill may be invoked to force an objecting physician to kill a patient or help with suicide.

Lawyer Joseph Arvay, acting for the appellants in *Carter*, opposed the Project's intervention at the Supreme Court of Canada because his clients had never argued that physicians should be forced to kill patients.[11] In his oral submission, he emphasized that no one was suggesting that objecting

physicians provide assisted suicide or euthanasia.[12]

This was quite true, and characteristic of the approach taken by activists seeking the legalization of morally contested procedures or the suppression of freedom of conscience among health care workers. They generally do not demand that objecting health care workers personally provide the service to which they object. They demand, instead, that objectors facilitate the service by helping patients obtain it from someone else. This is typically described as the problem of referral. Most of my presentation today will deal with that issue.

However, demands are also made that, in urgent situations, when no one else is available, objecting physicians must provide even services they find morally reprehensible (Tab 5, p. 31, 5.4; Tab 6, memo to Council, p. 7, 5.4) This becomes complicated because physicians do have an ethical and legal obligation to provide medical treatment in an emergency.

Objecting physicians do not dispute this, and, in the Project's experience, are quite willing to do so. However, there is a legitimate concern that the definition of "emergency" will prove to be as elastic as the definitions of "health" or the "best interests" of a patient have proved to be.

Nonetheless, this does not seem likely in the case of euthanasia and assisted suicide. The provision of the procedures is expected to include a number of procedural safeguards that will take some time, so it seems unrealistic to expect an emergency request for the services. The College of Physicians and Surgeons of Ontario, when it imposed a highly controversial policy of mandatory referral, explicitly stated that it would not consider a request for euthanasia or assisted suicide to be an emergency.[13]

So it would seem that concern that objecting physicians might be forced to provide euthanasia or assisted suicide in an emergency is unjustified, and claims to that effect best described as scaremongering.

However, there is evidence that such situations can arise. It was provided to the Quebec legislative committee studying the bill that has since become the province's euthanasia law. I believe that the transcripts are still available only in French (except on the Project's website), so this information is largely unknown outside of Quebec, and I don't know how widely it is known there.

Representatives of the College of Pharmacists of Quebec who appeared before the committee agreed that the provision of euthanasia would not seem to involve "the same urgency" as other kinds of procedures.[14] However, they distinguished between making a decision that euthanasia should be provided - a decision which might take days or weeks - and a decision that a drug must be urgently administered to deal with an unanticipated and critical development in a patient's condition.[15] For example, palliative sedation was sometimes urgently requested as a result of respiratory distress precipitated by sudden bleeding.[16]

With this in mind, consider the following scenario. After following the required protocols, a Vancouver physician, on a Friday, agrees to provide euthanasia or assisted suicide for an eligible patient. However, they schedule the procedure for the following Tuesday so that a family member working in camp near Fort St. John can be at the bedside. On Saturday night, an unexpected crisis causes the patient and family to ask for an immediate lethal injection to put an end to the patient's suffering.

No problem will arise if the responsible physician is immediately available to fulfil the request. However, if the responsible physician has gone to Whistler for the weekend, is attending a mother in labour or is otherwise unavailable, another physician may be called upon to provide the lethal injection, and may be expected to do so because the patient is urgently in need of relief.

A conflict is likely to arise if the physician is morally opposed to euthanasia. According to the *Model Conscientious Objection Policy* proposed by an academic trio including one of Canada's foremost euthanasia advocates, Jocelyn Downie, this physician would be obligated to kill the patient or find someone willing and able to do so immediately (Tab 5, p. 31, 5.4). Earlier this year the College of Physicians and Surgeons of Saskatchewan attempted to enact a virtual clone of this model policy - including this provision (Tab 6, memo to Council, p. 5-7; *Policy- Conscientious Refusal*).

In view of the explanation provided by Quebec pharmacist representatives and the apparent popularity of the *Model Conscientious Objection Policy* among some medical regulators, it is not scaremongering to draw attention to this issue. It is a foreseeable problem that ought to be addressed, not only to protect freedom of conscience, but to avoid needless conflict and distress to patients, families an other health care workers in particularly trying circumstances. For these reasons, the Project offers the following recommendations.

Recommendations to avoid conflict in urgent situations

5) A responsible physician who has agreed to provide euthanasia or assisted suicide must be continuously available to do so from the time the agreement is made to the time that the procedure is performed, unless the patient withdraws the request.

6) A responsible physician who has agreed to provide euthanasia or assisted suicide must also arrange for a second responsible physician to provide the procedure in the event that he is unable to be continuously present or is unable to act.

7) The second responsible physician must be continuously available to act in the place of the primary responsible physician.

Eligibility criteria and definition of key terms

The panel has asked for feedback on eligibility criteria and definition of key terms. Since the Project does not take a position on the acceptability of euthanasia or physician assisted suicide, my comments here limited to reflections on conflicts of conscience that may arise as a result of the criteria or the terminology, and corresponding threats to freedom of conscience.

Terminology

With respect to terminology, I first return to the point I raised at the outset: the language used to identify the morally contested acts. To demand that those who object to euthanasia and assisted suicide for reasons of conscience adopt the language of euthanasia and assisted advocates is to deprive them of the words they must use to succinctly and clearly express the basis for their opposition: homicide, suicide, euthanasia, killing.

It does not follow from this that objecting physicians should always use this language. Prudence

may suggest otherwise, particularly when attempting to engage productively with colleagues or patients. Recall, here, my earlier comments; objecting physicians care deeply for their patients. On the other hand, prudence may also suggest that, even in such circumstances, direct language is required, particularly when faced with demands that they kill patients, help them to commit suicide or find someone willing to do so.

Eligibility criteria

The eligibility criteria offered by the Supreme Court are very broad, and they have been the subject of extensive public comment since the ruling. One word that seems to have escaped notice is "including" - in the passage, "a grievous and irremediable medical condition, (including an illness, disease or disability.)" The real significance of "including" here is not that it encompasses disability, but that it encompasses unspecified conditions beyond illness, disease and disability: frailty, for example,[17] or "failure to thrive."[18]

Beyond that, it is certain that the parameters set by *Carter* will be expanded. For example: Quebec's euthanasia law is supposed to apply only to competent adults, but, even before the law was passed, the government was being pressured by various establishment organizations to expand the law to authorize euthanasia by advance directives and extend euthanasia to the mentally ill and children. (Tab 13, p. 45-49)

Joseph Arvay, counsel for the appellants, acknowledged in his oral submission that this kind of expansion can occur and has occurred in Belgium, but described it as ordinary and unproblematic: "construction of legislation," "the democratic process working," and "the *Charter* working."[19]

Two elements in the draft policy now being considered by the College of Physicians and Surgeons of Alberta are of interest here.

With respect to the criterion of "intolerable suffering," the proposed policy limits the role of physicians to establishing the existence of an irremediable medical condition, leaving the patient to determine all issues related to the existence and nature of suffering. In effect, the policy sets one of the legal criteria that physicians must ensure are met outside the purview of physicians. (Tab 11, p. 7, 6. Medical opinion)

However, it would not be unreasonable for physicians - even those who do not object to euthanasia and assisted suicide - to take the position that they must somehow be satisfied that a patient is experiencing intolerable suffering, since this is one of the criteria that they must establish to qualify for exemption from prosecution for murder and assisted suicide. Note that, in a prosecution for murder, the patient would not be available to testify as to the existence and intolerability of suffering.

The second element in the Alberta draft policy is the provision that envisages the provision of euthanasia and assisted suicide to put an end to suffering caused by "depression" or a "psychiatric or psychological disorder," on the condition that physicians establish that the depression or disorder is not "causing" impaired judgement. (Tab 11, p. 7, 7. Referral for pscyhiatric/psychological assessment)

These issues are relevant from the perspective of the Project because the broader the criteria for a morally contested procedure, the greater the likelihood of conflicts of conscience and conscientious

objection, and, consequently, the greater the need for robust protection of conscience policies and laws.

Referral: the "absolutely intractable" problem

I now turn to what one frustrated professor has called the "absolutely intractable" problem of referral.[20] This is not a new problem. The Project has been dealing with it continually for fifteen years, and for fifteen years has predicted the controversy that is now underway about this issue as a result of the *Carter* ruling. I will presently explain that referral has been a contentious issue in Canadian health care for over forty years.

First, however, it is important to recognize what is meant by referral. It has a specific, technical meaning: a written request by a physician to another physician or specialist requesting the examination or treatment of a patient. However, in debates and disputes about freedom of conscience in health care, it typically has a broader, popular meaning: helping patients to obtain a morally contested service by directing them to someone who will provide it, with or without a technical written referral.

It is in this broader sense that I use it today: actively helping a patient to obtain a morally contested service. Many objecting physicians refuse to do this, for the reason very succinctly explained by the President and Director General of Quebec's Collège des médecins, Dr. Charles Bernard. He said,

> [I]f you have a conscientious objection and it is you who must undertake to find someone who will do it, at this time, your conscientious objection is [nullified]. It is as if you did it anyway. / [Original French] Parce que, si on a une objection de conscience puis c'est nous qui doive faire la démarche pour trouver la personne qui va le faire, à ce moment-là , notre objection de conscience ne s'applique plus. C'est comme si on le faisait quand même.[21]

Ironically, Dr. Bernard seemed unaware that he was in conflict with his own *Code of Ethics*, which requires objecting Quebec physicians to help patients find a physician willing to do what they are unwilling to do for reasons of conscience. This is discussed at length in relation to Quebec's euthanasia law at Tab 13, p. 117-128.

In any case, the central issue for objecting physicians is unacceptable complicity in what they consider to be an immoral act. Different physicians may draw the line in different places. For example, some are willing to provide a phone number or address for an abortion clinic, but others will only direct a patient to general public sources where that information can be found. Despite these differences, the desire to avoid complicity in wrongdoing is actually a well understood and widely accepted ethical concern - as Dr. Bernard said - and I need not dwell on it here.

The Project does not take a position on the morality or acceptability of referral, just as it does not take a position on the acceptability of morally contested procedures. However, the Project opposes coerced referral, or punishment or discrimination against health care workers who, for reasons of conscience, refuse to facilitate what they believe to be wrong by referral or other means.

The CMA and referral

The Canadian Medical Association has experienced numerous conflicts about referral, but most

Canadian physicians now in practice are probably unaware of the history of the issue. (Tab 4)

The current provision of the *CMA Code of Ethics* that deals with conscientious objection dates to the major 1970 revision of the *Code* following the reform of the abortion law in 1969. Physicians were expected to advise patients of personal moral beliefs that might prevent them from recommending a treatment so that the patient could seek the treatment elsewhere. This approach was supported by resolutions at the Annual General Council in Halifax in 1971.

However, skyrocketing abortion rates in the early 1970's generated demands that objecting physicians provide or facilitate the procedure. In 1977 the Annual General Council revised the *Code* to include a requirement that objecting physicians "advise the patient of other sources of assistance." Supporters of the revision justified it by appealing to the principles of compassion and non-abandonment.

The revision was widely understood to imply an obligation to refer patients for abortion. This generated considerable controversy within the Association, and in 1978 the requirement was deleted and the earlier provision concerning conscientious objection was restored. Physician were expected to advise patients about procedures they would not provide

For the next thirty years the CMA maintained this position, despite demands and criticism by pro-abortion activists. One of these was Professor Jocelyn Downie. As co-author of a 2006 guest editorial in the *Canadian Medical Association Journal*, she claimed that objecting physicians have an ethical and legal obligation to refer patients for abortions. The strong adverse response persuaded her that the CMA was unlikely to change its policy, and she decided to approach provincial Colleges of Physicians to use their regulatory power to force the change she wanted to see.

In 2011 she was one of six members of an "expert" panel of the Royal Society of Canada that recommended legalization of physician assisted suicide and euthanasia. Despite the outcome of Downie's 2006 editorial, their report stated that *because* it was agreed that health care workers could be forced to refer for "reproductive health services" that were contrary to their moral convictions, they could also be forced to refer for euthanasia and assisted suicide.

Jocelyn Downie and Daniel Weinstock, another member of the Royal Society expert panel, are members of the faculty[22] of the "Conscience Research Group."[23] This is a quarter-million dollar Canadian Institutes of Health Research (CIHR) funded project.[24]

A central goal of the group is to entrench in medical practice a duty to refer for or otherwise facilitate contraception, abortion and other "reproductive health" services. From the perspective of many objecting physicians, this amounts to imposing a duty to do what they believe to be wrong. But that is just what the Royal Society experts and the Conscience Research Group and others propose: that the state or a profession can impose upon physicians a duty to do what they believe to be wrong.

The *Model Conscientious Objection Policy* in Tab 5 was produced by the Group, which, in 2013, began lobbying Colleges of Physicians across the country to adopt it.(Tab 6, Project Submission, Appendix "B", B.II) It demands that objecting physicians refer patients for all "legally permissible and publicly funded health services," and, in urgent circumstances where delay jeopardizes a patient's "health or well-being", provide the service themselves, even if doing so violates their moral convictions. Euthanasia and physician assisted suicide will soon be "legally permissible and publicly funded health services."

The influence of the Conscience Research Group is demonstrated by the fact that the Associate Registrar of the College of Physicians and Surgeons of Saskatchewan copied their model policy almost verbatim and succeeded in having it approved in principle by the College Council. (Tab 6, *Policy- Conscientious Refusal*; Project Submission Appendices "A" and "B") The policy was proposed with the legalization of assisted suicide in mind (Tab 6, Memo to College Council, p. 8). After the Carter decision, the Associate Registrar acknowledged that the policy would apply to assisted suicide, and that physicians unwilling to refer patients for assisted suicide might lose their licenses to practise. (Tab 6, Project Submission Appendix "C", p. 56) He also attempted to convince Registrars in other Colleges to adopt the policy, explicitly referring to the possible legalization of assisted suicide and euthanasia. (Tab 6, Project Submission Appendix "B", BV)

As a result of overwhelming opposition from the medical profession and the public, the original draft policy was withdrawn. However, the Associate Registrar and drafting committee continued to put forward alternatives intended to achieve the same end. Eventually, a problematic but somewhat less objectionable policy was adopted. It includes a proviso that it does not apply to assisted suicide and euthanasia. However, the Project considers this statement to be a disingenuous tactic adopted to help secure approval of the policy. Almost all of the principles advanced to support the policy have been advanced to support euthanasia or assisted suicide. (Tab 6, Project Submission 5 June, 2015, Appendix "C")

Parts of the Conscience Research Group's model policy have also been copied almost verbatim into the College of Physicians and Surgeons of Alberta draft policy on Physician Assisted Death. (Tab 11, p. 5, 9)

Finally, returning once more to the CMA, erroneous and misleading briefing materials provided to delegates at the Annual General Council suggest a bias in favour of referral on the part of some CMA officials. (Tab 8) Fortunately, this does not appear to have adversely affected the outcome, but it is indicative of the tendency to consider mandatory referral as the preferred response to conscientious objection.

Referral and risks to individuals and society

The panel has asked for feedback about risks to individuals and society posed by the *Carter* decision. From the perspective of the Project, coerced referral for euthanasia and assisted suicide present unacceptable risks to the fundamental freedom of individuals and groups or associations united by common religious, moral or ethical convictions that proscribe support for or participation in such practices. Beyond that, coerced referral presents an unacceptable risk to society.

What is now being advanced by the Conscience Research Group, some medical regulators and influential academics is the dangerous idea that a learned or privileged class, a profession or state institutions can legitimately compel people to do what they believe to be wrong - even gravely wrong - even killing someone or being a party to homicide or suicide - and punish them if they refuse.

This is not a reasonable limitation of fundamental freedoms, but a reprehensible attack on them.

It is a serious violation of human dignity.

It is incoherent, because it posits the existence of a moral or ethical duty to do what one believes to be wrong: that physicians codes of ethics should include a duty to do what they believe to be

unethical.

And it is profoundly dangerous. If the state can demand that citizens must be parties to killing other people and threaten to punish them or discriminate against them if they refuse, what can it not demand?

The silence of traditional defenders of civil liberties on this issue is remarkable.

We do not use criminal law to enforce fundamental rights and freedoms *per se.* For that we rely upon human rights statutes. But we do use the criminal law to prevent and to punish particularly egregious violations of fundamental freedoms that also present a serious threat to society: unlawful electronic surveillance, unlawful confinement and torture, for example.

Coercion or intimidation intended to force citizens to become parties to homicide or suicide is both an egregious violation of fundamental freedoms and a serious threat to society that justifies the use of criminal law. For this reason, whatever might be decided about laws regulating euthanasia and assisted suicide, the Project proposes the following amendment to the *Criminal Code*.

An Act to Safeguard Against Homicide and Suicide
Section 241.1 Criminal Code

Compulsion to participate in homicide or suicide
241.1(1) Every one commits an offence who, by an exercise of authority or intimidation, compels another person to be a party to homicide or suicide.

Punishing refusals to participate in homicide or suicide
241.1(2) Every one commits an offence who

a) refuses to employ a person or to admit a person to a trade union, professional association, school or educational programme because that person refuses or fails to agree to be a party to homicide or suicide; or

b) refuses to employ a person or to admit a person to a trade union, professional association, school or educational programme because that person refuses or fails to answer questions about or to discuss being a party to homicide or suicide.

Intimidation to participate in homicide or suicide
241.1(3) Every one commits an offence who, for the purpose of causing another person to be a party to homicide or suicide

a) suggests that being a party to homicide or suicide is a condition of employment, contract, membership or full participation in a trade union or professional association, or of admission to a school or educational programme; or

b) makes threats or suggestions that refusal to be a party to homicide or suicide will adversely affect

i) contracts, employment, advancement, benefits, pay, or

ii) membership, fellowship or full participation in a trade union or professional association.

Definitions

241.1(4)(a) For the purpose of this section, "person" includes an unincorporated organization, collective or business.

b) For the purpose of subsection (1), "homicide" and "suicide" include attempted homicide and suicide.

Punishment

241.1(5) a) Every one who commits an offence under subsection (1) is guilty of an indictable offence and liable to imprisonment for life.

b) Every one who commits an offence under subsection (2) is guilty of an indictable offence and liable to imprisonment for ten years.

c) Every one who commits an offence under subsection (3) is guilty of an indictable offence and liable to imprisonment for five years.

Safeguards to address risks

The amendment to the *Criminal Code* proposed above, while intended to protect society at large against particularly dangerous abuses of authority or power and violations of fundamental freedoms, will also function as an additional safeguard against abuses that even the successful appellants in the *Carter* case are keen to avoid.

In his oral submission, Mr. Arvay asserted that he was advocating physician assisted dying "because we know physicians will be reluctant gatekeepers, and only agree to it as a last resort." (Tab 7, p. 43) The proposed amendment will help to ensure that physicians can remain the reluctant gatekeepers that Mr. Arvay wishes them to be.

Further, the proposed amendment to the *Criminal Code* would ensure that, in all provinces and territories, a single standard would prevail to ensure participation of physicians in euthanasia and assisted suicide on an entirely voluntary basis, setting an important base line for consistent regulations developed by the federal government or in different provinces. This would also address one of the concerns consistently expressed by the Canadian Medical Association - the importance of a common standard across the country.

Acceptable model policies

It is possible that adequate protection of conscience measures will be adopted by regulators and institutions. The draft policy proposed by the College of Physicians and Surgeons of Alberta could be improved in some respects, but the key elements are sound. (Tab 11, p. 9) The Canadian Medical Association's recommendation concerning conscientious objection by a physician is satisfactory (Tab 9, p. A2-6, 5.2).

Both the Alberta and CMA recommendations distinguish between the provision of all information necessary for a patient to make an informed decision about options (required) and directing the patient to someone who will provide euthanasia or assisted suicide (not required). In the Project's experience, this distinction and the obligation to provide information are accepted by most objecting physicians.

This approach is found in the Project's suggested policy on freedom of conscience and religion at

Tab 10 in the Project Submission, Appendix "A", which can be applied to all morally contested procedures. Note that the same is true of the Alberta College document through its reference to the College's primary policy about religious and moral beliefs.

Recommendations:

8) It is preferable to have a single policy concerning the exercise of freedom of conscience and religion that can be applied to all morally contested procedures. This helps to avoid bias that occurs when some morally contested procedures are given a privileged position based on a predominant moral viewpoint (i.e., requiring referral for contraception but not for abortion, or for abortion but not for euthanasia, etc.)

9) A distinction can be made between providing information needed for informed medical decision making (required) and facilitating direct access to a morally contested service (not required).

Position of objecting physicians

The position of objecting physicians and health care workers will be tenuous until Members of Parliament decide that citizens must not be forced to be parties to homicide or suicide, should not be punished or discriminated against for refusing to be parties to homicide or suicide, and amend the *Criminal Code* to ensure that such things do not happen.

There are three reasons why, in the absence of such a law, the position of objecting physicians will be uncertain.

First: the history of the controversy within the CMA about referral, which has arisen repeatedly over forty years, suggests that physicians and other health care workers will likely face conflict about euthanasia and assisted suicide and pressure to participate, perhaps for decades.

Second: the *Carter* decision provides an exemption from prosecution for murder and assisted suicide for physicians who kill patients or help them commit suicide in the circumstances described in the ruling. It prevents the government from interfering to prevent that, but it does not actually require individual physicians or the medical profession as a whole to provide or arrange for euthanasia or assisted suicide. Nonetheless, some - including the College of Physicians and Surgeons of Alberta - claim that the *Carter* ruling provides a *Charter* right to physician assisted suicide or homicide by a physician. (Tab 11, p. 4) This is a powerful rhetorical claim that is likely to be used to try to force physicians to do what they believe to be wrong.

Third: Having secured the passage of a resolution promising support for physician freedom of conscience and neutrality on the issue of physician participation in euthanasia and assisted suicide, the CMA executive not only reversed CMA policy against the practices, but approved euthanasia and assisted suicide under any conditions set by law, without promised to ensure patient access to "the full spectrum" of euthanasia an assisted suicide should the practices be legalized, *no matter what the criteria might be.*(Tab 7)

The revised policy does not exclude euthanasia or assisted suidice for minors, the incompetent, or the mentally ill, and it is not limited to the terminally ill or those with uncontrollable pain. It refers only to "patients" and the "suffering of persons with incurable diseases. The Directors thus committed the Association to support euthanasia not only for competent adults, but for any patient group and for

any reason approved by the courts or legislatures. As broad as the *Carter* ruling is, it is more restrictive than CMA policy.(Tab 7)

By formally approving physician assisted suicide and euthanasia rather than adopting a neutral position, and by committing the CMA to support patients's access to physician assisted suicide and euthanasia under conditions set by law, the Directors implicitly agreed that, in some circumstances, physicians have a professional obligation to kill patients or to help them kill themselves.(Tab 7)

This effectively set the weight and influence of the entire Association against physicians who believe that it is wrong to participate in killing patients or helping them to kill themselves, or, at least, that physicians should not do so, even if someone else may. When euthanasia and assisted suicide are considered legitimate forms of medical treatment, providing the services become normative for physicians, while refusing to do so becomes the exception.(Tab 7)

Hence, the Directors agreed that freedom of conscience for objecting physicians might be limited in order to ensure patient access, but they placed no limits on criteria for euthanasia and assisted suicide, and no limits on what the Association and non-objecting physicians might agree to do.(Tab 7)

The long term consequences of all of this are unpredictable, particularly in the absence of a law to prevent coercion.

Notes

1. "The term killing does not necessarily entail a wrongful act or a crime, and the rule 'Do not kill' is not an absolute rule. Standard justifications of killing, such as killing in self-defense, killing to rescue a person endangered by another persons' wrongful acts, and killing by misadventure (accidental, non-negligent killing while engaged in a lawful act) prevent us from prejudging an action as wrong merely because it is killing." Beauchamp TL, Childress JF, *Principles of Biomedical Ethics* (7th ed.) New York: Oxford University Press, 2013, p. 176

2. *Trinity Western University v. the British Columbia College of Teachers*, [2001] 1 S.C.R. 772, 2001 SCC 31. Approving *P. (D.) v. S. (C.)*, [1993] 4 S.C.R. 141 (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1867/index.do) Accessed 2014-03-11.

3. "As for the People [of Ireland], what thoughts they have in matters of Religion in their own breasts I cannot reach; but shall think it my duty, if they walk honestly and peaceably, Not to cause them in the least to suffer for the same. . . ", but ". . . I shall not, where I have the power, and the Lord is pleased to bless me, suffer the exercise of the Mass . . . nor . . . suffer you that are Papists, where I can find you seducing the People, or by any overt act violating the Laws established; but if you come into my hands, I shall cause to be inflicted the punishments appointed by the Laws." Cromwell, Oliver, "Declaration of the Lord Lieutenant of Ireland." (January, 1649) Carlyle, Thomas, *Oliver Cromwell's Letters and Speeches, with elucidations*. Boston: Estes and Lauriat, 1886, Vol. I, Part 5, p. 18.

4. *Act Respecting End of Life Care*, Section 30 (https://www.canlii.org/en/qc/laws/stat/rsq-c-s-32.0001/latest/rsq-c-s-32.0001.html) Accessed 2015-07-08)

5. Ubelacker S. "Quebec MDs to get euthanasia guide to prepare for legalized assisted death: Unclear whether other provinces and territories will adopt a similar practice."*The Canadian Press*, 1 September, 2015 (http://www.cbc.ca/news/canada/montreal/quebec-mds-to-get-euthanasia-guide-to-prepare-for-legalized-assisted-death-1.3212081) Accessed 2015-09-03.

6. Groenewoud JH, van der Heide A. Onwuteaka-Philipsen BD Willems DL van der Maas PJ, van der wal G., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands." *N Engl J Med* 2000; 342:551-556 February 24, 2000

7. Moore E. "Doctor is hoping feds will guide on assisted suicide legislation." *Edson Leader*, 12 February, 2015. (http://www.edsonleader.com/2015/02/12/doctor-is-hoping-feds-will-guide-on-assisted-suicide-legislation) Accessed 2015-07-16.

8. Rich, P. "Physician perspective on end-of-life issues fully aired." *Canadian Medical Association*, 19 August, 2014 (https://www.cma.ca/En/Pages/Physician-perspective-on-end-of-life-issues-fully-aired.aspx) Accessed 2015-06-22

9. Ubelacker S. "Medical professionals try to answer burning questions on doctor-assisted death." *Associated Press*, 13 February, 2015 (http://www.1310news.com/2015/02/13/medical-professionals-try-to-answer-burning-questions-on-doctor-assisted-death/) Accessed 2015-07-04

10. Kirkey S. "How far should a doctor go? MDs say they 'need clarity' on Supreme Court's assisted suicide ruling." *National Post*, 23 February, 2015 (http://news.nationalpost.com/news/canada/how-far-should-a-doctor-go-mds-say-they-need-clarity-on-supreme-courts-assisted-suicide-ruling) Accessed 2015-07-04.

11. In the SCC on appeal from the BCCA, *Appellants' Response to Motions to Intervene*, 20 June, 2014, para. 5(c) (http://www.consciencelaws.org/archive/documents/carter/2014-06-20-response-to-interventions.pdf)

12. Murphy S. "Re: Joint intervention in *Carter v. Canada* -Selections from oral submissions." Supreme Court of Canada, 15 October, 2014. Joseph Arvay, Q.C. (Counsel for the Appellants). *Protection of Conscience Project.* (http://consciencelaws.org/law/commentary/legal073-009.aspx#Joseph_Arvay)

13. College of Physicians and Surgeons of Ontario, *Professional Obligations and Human Rights: Frequently Asked Questions*. (http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/Human-Rights-FAQ.pdf?ext=.pdf) Accessed 2015-10-17

14. Consultations & hearings on Quebec Bill 52, *College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert*. Tuesday 17 September 2013 - Vol. 43 no. 34, T#49, T#58 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#049; http://www.consciencelaws.org/background/procedures/assist009-005.aspx#058) (Hereinafter "Consultations")

15. Consultations, *College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert.* Tuesday 17 September 2013 - Vol. 43 no. 34, T#76, T#87, T#88 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#076) (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#087) (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#088)

16. Consultations, *College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert.* Tuesday 17 September 2013 - Vol. 43 no. 34, T#33 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#033)

17. Cimons M. "Frailty Is a Medical Condition, Not an Inevitable Result of Aging (Op-Ed)." *Livescience*, 29 November, 2013. (http://www.livescience.com/41602-frailty-is-medical-condition.html) Accessed 2015-06-28.

18. Robertson RG, Montagnini M. "Geriatric Failure to Thrive." *Am Fam Physician*. 2004 Jul 15;70(2):343-350. (http://www.aafp.org/afp/2004/0715/p343.html) Accessed 2015-10-26)

19. Supreme Court of Canada, Webcast of the Hearing on 2014-10-15, 35591, *Lee Carter, et al. v. Attorney General of Canada*, et al (British Columbia) (Civil) (By Leave). *Joseph Arvay, Oral Submission*, 82:49/491:20 - 88:25/491:20 (http://www.scc-csc.gc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1938/201410150500wv150en,001&urlfr=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1940/201410150500wv150en,001&date=2014-10-15) Accessed 2015-06-28

20. Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise.* Cambridge, Mass.: The MIT Press, 2008, p. xii-xiii (hereinafter "*Conflicts*.") p. 233. Quoting Veatch, Robert M., *The Patient-Physician Relation: The Patient as Partner*, Part 2. Bloomington Indiana University Press, 1991, p. 152

21. Consultations, *Collège des médecins du Québec, Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand.* Tuesday 17 September 2013 - Vol. 43 no. 34, T#154 (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#154)

22. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 101 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2015-10-28

23. *Let their conscience be their guide? Conscientious refusals in reproductive health care.* (http://conscience.carolynmcleod.com/meet-the-team/) Accessed 2015-10-28.

24. Canadian Institutes of Health Research, *Let Conscience Be Their Guide? Conscientious Refusals in Reproductive Health Care- Project Information.* (http://webapps.cihr-irsc.gc.ca/funding/detail_e?pResearchId=5615697&p_version=CRIS&p_language=E&p_session_id=) Accessed 2015-10-28

*** News Release**

Government of Canada Establishes External Panel on options for a legislative response to Carter v. Canada

Panel to consult with stakeholders and all Canadians

July 17, 2015 – Ottawa, ON – Department of Justice. Today, Minister of Justice and Attorney General of Canada Peter MacKay and Minister of Health Rona Ambrose announced the establishment of an external panel that will consult with Canadians on options to respond to the Supreme Court of Canada's decision in *Carter v. Canada*.

The panel will conduct consultations with medical authorities and with interveners in the Carter case to assist the federal government in formulating a legislative response to the Supreme Court's decision. The panel will also consult Canadians, including interested stakeholders, through a public online consultation. The panel will then provide a final report to the Ministers of Justice and Health that outlines its findings and options for a legislative response for consideration by the federal government.

The panel includes three members:

- Chairman, Harvey Max Chochinov, MD, PhD, FRCPC, Distinguished Professor of Psychiatry and Canada Research Chair in Palliative Care at the University of Manitoba, and Director of the Manitoba Palliative Care Research Unit, CancerCare Manitoba;
- Catherine Frazee, D.Litt., LL.D., Professor Emerita at Ryerson University, where, prior to her retirement in 2010, she served as Professor of Distinction and Co-Director of the Ryerson-RBC Institute for Disability Studies Research and Education; and
- Benoît Pelletier, LL.B., LL.M., LL.D., LL.D., Professor of Law, University of Ottawa, constitutional expert and former member of the National Assembly of Quebec from 1998 to 2008, and Quebec Cabinet minister from 2003 to 2008.Quick Facts

Quick Facts

On February 6, 2015, the Supreme Court of Canada's decision in Carter v. Canada held that sections 241(b) and 14 of the Criminal Code violate the constitutional rights of certain grievously and irremediably ill adult individuals. These sections of the Criminal Code currently make it illegal for anyone, including a doctor, to assist in or cause the death of another person.

The Court ordered that the Criminal Code provisions remain in force for 12 months to give Parliament time to respond.

The panel's mandate is to consult with Canadians and key stakeholders - with a focus on the interveners in the Supreme Court case, who represent a spectrum of diverse perspectives - on considerations relevant to a federal legislative response to the Carter decision. The Panel will provide a final report to the Ministers of Justice and Health that outlines its findings and options for a legislative response for consideration by the Government.

The panel will provide its report to the Government by late Fall 2015. . .

Submission Binder

Tab 1 Recommendations

Tab 2 About the Protection of Conscience Project

Tab 3 Journal of Bioethical Inquiry, Freedom of Conscience in Health Care: Distinctions and Limits.

Tab 4 Canadian Medical Association - Referral: from abortion to euthanasia (1970-2015) Part I: Background (1970-2011)

Tab 5 Conscience Research Group (Downie et al) Model Conscientious Objection Policy

Tab 6 College of Physicians and Surgeons of Sask. - Conscientious Objection
Appendices from Project submission re: Conscientious Objection

- A- Origin of CPSS Draft Policy Conscientious Objection
- B- Development of CPSS Draft Policy Conscientious Objection
- C- Interview of Associate Registrar, College of Physicians and Surgeons of Sask.

Tab 7 Canadian Medical Association -Referral: from abortion to euthanasia (1970-2015) Part II & III (2012-2014)

Tab 8 CMA Backgrounder, Schedule "B": Legislative criteria across jurisdictions (Annotated).

Tab 9 CMA Principles Based Recommendations for a Canadian Approach to Assisted Dying

Tab 10 College of Physicians and Surgeons of Sask. - Physician Assisted Dying (Draft)
Project submission to the CPSS re: above

Tab 11 College of Physicians and Surgeons of Alta. - Consent, Physician Assisted Death

Tab 12 Project Submission to the Provincial/Territorial Expert Advisory Group on Physician Assisted Dying (23 September, 2015).

Tab 13 Redefining the Practice of Medicine: Euthanasia in Quebec (*An Act Respecting End of Life Care*) (June, 2014).

Tab 14 Legalizing therapeutic homicide and assisted suicide: A tour of *Carter v. Canada* (31 July, 2012).